

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |  |                            |  |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15G393</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>02/27/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DEVELOPMENTAL SERVICES INC</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>113 JENNINGS ST</b><br><b>NORTH VERNON, IN 47265</b>                         |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| {K 000}   | <p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the PSR conducted on 01/27/14 to the Life Safety Code Recertification Survey conducted on 12/19/13 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 02/27/14</p> <p>Facility Number: 000907<br/>Provider Number: 15G393<br/>AIM Number: 100244410</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this PSR survey, Developmental Services Inc. was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was determined to be fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 8 and had a census of 6 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.24.</p> | {K 000}  |  |                            |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |  |                            |  |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>15G393</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>02/27/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DEVELOPMENTAL SERVICES INC</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>113 JENNINGS ST</b><br><b>NORTH VERNON, IN 47265</b>                         |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| {K 000}   | Continued From page 1<br>Quality Review by Robert Booher, Life Safety<br>Code Specialist-Medical Surveyor on 03/03/14.       | {K 000}  |  |                            |  |